



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH FORT WORTH
3255 W PIONEER PKWY
ARLINGTON, TX 76013

Respondent Name

EMPLOYERS PREFERRED INS CO

Carrier's Austin Representative Box

Box Number 04

MFDR Tracking Number

M4-13-2065-01

MFDR Date Received

APRIL 16, 2103

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by THR FORT WORTH to audit their Workers Compensation claims. We have found in this audit you have not paid according the fee schedule. Inpatient claims are to be paid at 143% of Medicare when implants were not requested to be carved out of the reimbursement. DRG 603 allows \$5645.05 making the TDI allowable for this claim \$8072.42. Based on your payment of \$7435.24, a payment of \$637.18 is still due. We have attached a printout from the Medicare Inpatient Pricer for your reference. ***Please note – CMS has yet to update the Pricer as of the fiscal year change (October 1, 2012)."

Amount in Dispute: \$5,451.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier reviewed the position statement form Healthcare Recovery Alliance regarding payment for the hospital bill from Texas health Fort Worth for dates of service 8/14/12 to 8/19/12. Healthcare Recovery Alliance is seeking reimbursement based on an illegal method of reimbursement for this bill. This claim is not a Workers' Compensation Healthcare Network and there is no contract in place between the Insurance carrier and the healthcare provider regarding reimbursement for medical services. This bill was submitted five different times for audit and the carrier recommended the same reimbursement amount on each audit. This is the fourth different position letter received from Healthcare Recovery Alliance and each letter claims a different amount is owed by the carrier. The carrier's position is the provider's bill has been audited 5 times and payment was timely issued for the correct amount in accordance with the Texas Labor code and applicable fee schedule. The carrier respectfully requests Medical Fee Dispute Resolution refer the Healthcare Recovery Alliance position statement requesting reimbursement based on a clearly illegal method to Compliance and Practices for an investigation. The carrier attached the applicable EOBs and proof of payment and the documentation from Health Care Recovery for the prior requests for reconsideration claiming different amounts were owed."

Response Submitted by: Employers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2012 to August 19, 2012	Inpatient Hospital Surgical Services	\$5,451.39	\$637.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register* 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated September 11, 2012
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 1 – The charge for this procedure exceeds the fee schedule allowance
Explanation of benefits dated December 06, 2012
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 1 – The charge for this procedure exceeds the fee schedule allowance
Explanation of benefits dated December 13, 2012
 - 18 – Duplicate claim/service
 - 1 – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice)
 - *D – This item was previously submitted and reviewed with notification of decision issued to payor-provider
Explanation of benefits dated December 14, 2012
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 1 – The charge for this procedure exceeds the fee schedule allowance
Explanation of benefits dated December 28, 2012
 - 18 – Duplicate claim/service
 - 1 – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice)
 - *D – This item was previously submitted and reviewed with notification of decision issued to payor-provider
 - 2 – Reviewed; 12/14/2012 Orig CTL Number 20122540062902 Orig total recommended allowance \$7435.24
Explanation of benefits dated March 15, 2013
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 1 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”
No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).
2. §134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted

and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
- (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 603, and that the services were provided at TEXAS HEALTH FORT WORTH. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$5,645.05. This amount multiplied by 143% results in a MAR of \$8,072.42.
4. The division concludes that the total allowable reimbursement for the services in dispute is \$8,072.42. The respondent issued payment in the amount of \$7,435.24. Based upon the documentation submitted, additional reimbursement in the amount of \$637.18 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$637.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

Dispute Resolution Findings and Decision together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-481.